APPLICATION FOR APPROVAL OF THE QUALIFIED MEDICATION AIDE COURSE
State Form 47953 (R/4-03)
Indiana State Department of Health – Division of Long Term Care

INSTRUCTIONS: Please complete the appropriate sections on both sides of the application. **All applications must be completed in Sections A and D.**

SECTION A: Training program information

APPLICATION PURPOSE (check all that apply):
☐ Initial approval; ☐ Renewal; ☐ Add Instructor (Section B); ☐ Add Clinical Site (Section C);
☐ Remove Instructor: Name_____

Name of Facility:_____

Street Address:_____

PO BOX #:_____

City:_____State_____

ZIP:_____Phone number:_____Fax number:_____

CLASSROOM SITE: (if different from above)
Name:_____

Address:_____

City:_____State_____

ZIP:_____Phone number:_____

SECTION B: Program Instructor information

Name:_____

Nursing License #:_____ Vocational License #:_____

PLEASE PROVIDE SPECIFIC DATES & LOCATIONS FOR THE FOLLOWING:

QUALIFICATIONS:

COPIES OF THE Q.M.A. TRAIN-THE-TRAINER COURSE CERTIFICATE, R.N. LICENSE, OR VOCATIONAL LICENSE, MUST ACCOMPANY THIS APPLICATION

SECTION C: Practicum Sites

Name of Facility:_____

Address:_____City_____

Name of Facility:_____

Address:_____City_____

Name of Facility:_____

Address:_____City_____

SECTION D: Certification of QMA Program

I certify the above information is correct and the named facility/school in Section A will abide by the criteria set forth by 412 IAC 2.

_____ _____

Administrator of facility OR Director of non-facility based program Date

Mail completed application, along with requested documentation to:

INDIANA STATE DEPARTMENT OF HEALTH
DIVISION OF LONG TERM CARE
2 N. MERIDIAN ST., 4B
INDIANAPOLIS, IN 46204

Please use additional applications for more than one instructor. Also, keep a copy of this application for your records.